Society Reports.

AMERICAN NEUROLOGICAL ASSOCIATION.

Fifteenth Annual Meeting, held at Long Branch, N. J., June 26 and 27, 1889.

DR. E. C. SEGUIN, President, in the Chair.

The following Scientific communications were read and discussed.

DR. GEORGE W. JACOBY, of New York, read a paper, entitled:

A CONTRIBUTION TO THE STUDY OF ANÆSTHETIC LEPROSY, WITH SPECIAL REFERENCE TO PARTIAL SENSORY DISORDERS.

(*For complete paper see page 336.*)

The points to which particular attention should be paid in all cases were the electrical excitability of the muscles, the condition of the reflexes, the presence or absence of fibrillary twitchings, and the condition of sensation. Upon these data depended the diagnosis between anæsthetic leprosy and syringomyelia, as well as that of the central or peripheral localization of the leprous process. The conclusions arrived at by the author from the analysis of his own and other cases were that the differential diagnosis between the two diseases could not always be made; that partial sensory disorders are not characteristic of syringomyelia, but may occur in anæsthetic leprosy as well as in purely peripheral affections; and finally, that a differential diagnostic point between central and peripheral loss of temperature sense may lie in its complete loss in one case and its partial loss in the other.

DR. STARR said that the same question as to the differential diagnosis between syringomyelia and anæsthetic leprosy had only recently occurred to him. Three weeks ago he had seen a case with Dr. Prince A. Morrow, of New York, in which there had been a gradual onset of an atrophic and anæsthetic affection of the right arm. He came from the Sandwich Islands and has been exposed to leprosy. There was anæsthesia to temperature and pain, but not wholly to touch, along the hand and part of the arm. There were small reddish-brown spots on the arm, which Dr. Morrow considered leprous in character. The idea of syringomyelia at once occurred to him, but the history of exposure in a leprous country sufficed to make anæsthetic leprosy at least the more probable nature of the disease; but without such history it would have been almost impossible to make the diagnosis. As to the matter of partial loss of sensation in the cases of multiple neuritis and beriberi he had seen, the sensory loss was complete, with the exception, however, of muscular sense.

THE PRESIDENT remarked that he had now under observation a case of leprosy, but had as yet made no careful examination of the temperature sense. His case illustrated the ease of diagnosis at an early period, when confusion with syringomyelia could not occur. The patient had a wine-colored eruption on the entire left leg and part of the thigh, the foot being free, and there were three or four similar spots on other parts of the body. There was distinct analgesia and some anæsthesia in these areas, but there was no paralysis or atrophy. The patient had come from the Sandwich Islands. The well-defined limitation of anæsthetic areas showed that it could not be neuritis. Of late the anterior leg muscles had become paretic, but there was no reaction of degeneration. The left hand was beginning also to manifest similar symptoms. There were no ulcers.

DR. C. K. MILLS had seen two cases of leprosy. He thought the author's point with regard to partial sensory disorder very interesting, but he did not see why there should not be partial disturbance also in neuritis, and, in fact, in traumatic neuritis it was quite frequent. The nature of the sensory disturbance depended upon the extent of the injury to the nerve. In ordinary multiple neuritis it might be true, as Dr. Starr insisted, that there was complete loss of sensation, through destruction of all the sensory fibres. He did not see, however, why the sensation to cold should not be injured as much as any. It should be borne in mind that in all infectious diseases attacking the nervous system there was a tendency to seize upon the central as well as the peripheral portions at the same time.

DR. GRAY agreed with the last speaker as to partial sensory disorders met with at times in peripheral neuritis. He had observed them also in multiple neuritis, where, for instance, there was impairment of the touch and temperature senses, yet the pain was excruciating. He did not see that it was easy to diagnosticate syringomyelia, and Wichmann and Starr had given no rules for diagnosis in their pamphlets. He believed that no one had made a diagnosis of syringomyelia in life.

Dr. Starr stated that Schulze had made the diagnosis in three cases, which had been substantiated by autopsy. The points for diagnosis were the general conclusions drawn from a study of collected cases. Anna Bäumler had brought together one hundred and sixteen cases, to which thirty or more had since been added.

Dr. Gray thought these diagnostic points would apply to many other spinal lesions.

Dr. Birdsall had had ideas similar to Dr. Gray's as regarded the diagnostic indications in syringomyelia until he had read Roth's collection of cases. In a certain number of such cases there were clinical pictures differing altogether from those of other spinal lesions and from that of peripheral neuritis. Disturbance of the temperature sense was the particular characteristic. Still, the testing of this sense had been constantly neglected in studying other spinal cases, and it was possible that it might often be disturbed in other spinal disorders. It was hard to see how any other lesion could produce precisely the same symptoms as those of syringomyelia. It was a question whether tracts for temperature and pain could be localized in the cord. Peripheral nerve lesions might cause injury to some sense fibres and not to others, although generally all were injured, particularly where the inflamation was truncal in character. There might be partial sensory disturbance in dermal forms.

Dr. Gray said it was easy to localize disease in the anterior cornua, in the lateral and posterior columns of the cord, but the diagnosis of central lesions was very difficult. The fact that out of one hundred and fifty cases of syringomyelia only three have been diagnosticated during life proved the truth of his assertion. The diagnostic suggestions given were therefore empirical. The presence or absence of the temperature sense has not been sufficiently tested as yet. How would one distinguish a chronic central myelitis?

Dr. Birdsall stated that central myelitis began acutely, and thus differed from the slow advance of syringomyelia.

Dr. Mills thought the question of partial sensory disorder most interesting. But he thought that there would be more apt to be partial disturbance in a truncal than in a dermal neuritis.

Dr. Frederick Peterson, of New York, asked the president if the tendon reflexes had been exaggerated in his case of leprosy, and was answered in the affirmative. He had asked this because he had recently read an interesting study of the reflexes in anæsthetic leprosy made by Dr. Suzuki, of Tokio, and published in the "Sei-a-Kwai" medical journal, in which there was an analysis of seventeen cases. One patient had normal reflexes, while all the others had increased tendon jerks, and in some of the cases there was even ankle clonus. The conclusions arrived at by the author were similar to Dr. Jacoby's.

The PRESIDENT called attention to the fact that so many cases of leprosy were now being continually imported into the United States. It seemed as if the country was threatened with its domiciliation It was a question whether it was not the duty of physicians having such cases to report them to the authorities.

DR. WHARTON SINKLER, of Philadelphia, mentioned the recent presence of two cases in Philadelphia. The physician in charge had been fined by the Board of Health for not reporting them.

DR. PRINCE wondered at the manner in which leprous patients were allowed to go about, and thought also that the attention of the authorities ought to be called to the disease, and reports to the boards of health be required.

DR. GRAY knew that in the East, where the disease was prevalent, isolation was practiced. He wished to know what the actual danger of contagion was.

DR. BRILL said that the attention of the New York Board of Health had already been called to the matter.

DR. JACOBY said that Schulze was altogether too positive in his assertions. This author went so far as to contend that cases of leprosy, where cavities had been found in the cord, were not leprosy at all, but syringomyelia. As for himself he thought a central lesion probably often existed in this disease, although it was well-known that the essential pathology lay in a truncal neuritis. A simple dermal neuritis could not be assumed in leprosy. In his case, for instance, the indurated and swollen ulnar nerve could be distinctly felt. He did not agree with Dr. Gray that the diagnosis of syringomyelia could not be made. The only danger lay in mistaking it for leprosy. He had only last evening come across the work of Suzuki mentioned by Dr. Peterson, but had noticed the identity of that author's conclusions with his own, although they had been arrived at from different points of view.

DR. J. H. LLOYD, of Philadelphia, read a paper entitled:

A LATER HISTORY OF A CASE OF FOCAL EPILEPSY, FOR WHICH TREPHINING AND EXCISION OF THE MOTOR CENTRES WERE PERFORMED.

(*For complete paper see page 356.*)

Full details of the case had been recorded at the last annual meeting of the Association. At that time but three months had elapsed since the operation, and Dr. Ferrier, of London, had stated in a discussion that the time was too short for a decisive result as to the usefulness of the operation. Now that more than a year had passed, further details could be given. Before the operation the patient had had many seizures daily. There was no fit for four months after the operation. Since that time, however, there had been some ten seizures in nine months.

DR. SPITZKA said there was a minority, but a powerful minority, of clinicians and physiologists who hesitated to accept the dictum that spasms were always of cortical origin when clonic in character and local in manifestation. There were well-authenticated cases of spasms, such as are generally described as cortical, which undoubtedly had their origin in the pons or medulla. He therefore thought it premature to advise surgical procedure when there was still doubt as to the position of the convulsive centre. He was of opinion that the seat of irritation in the great majority of cases of epilepsy was in lower centres, such as Nothnagel's convulsive centre.

DR. MILLS mentioned the case of a man subject to unilateral convulsions beginning in the hand. There was a scar upon the head, and trephining was done at this spot in order to relieve severe pain, probably due to trigeminal irritation in the scalp or dura. This operation relieved the pain, but caused the Jacksonian epilepsy upon the other side. The operation was repeated in the same spot, the membranes and cortex being removed to some extent, with great success. It was an apparent illustration of the fact that convulsions may occasionally be the result of operations themselves,

DR. DERCUM had seen the same case, and stated that the dura was not opened in the first operation. At the second trephination the membranes were found united. There was a pachymeningitis. The patient had surgical epilepsy. Six months elapsed between the operations.

DR. LLOYD said it was a question whether one could have localized epilepsy from irritation of lower centres, as Dr. Spitzka had intimated. He had always held the idea that such spasms were of cortical origin. In the case he had just described the absence of fits for four months led him to believe that he had removed the parts concerned in their manifestations. He had been hopeful of the efficacy of this method in the relief of such a disorder, and was not yet willing to give up the idea that something may be accomplished in this way. He thought it would be justifiable to operate again in this same case.

DR. SPITZKA asked if the cortex removed had been examined microscopically, and what was the pathological condition found.

DR. LLOYD answered that the microscopist had reported atrophy of the cortical cells.

DR. SPITZKA remarked that atrophied cells could scarcely be very potent in the production of epilepsy.

MULTIPLE NEURITIS AND INFECTIOUS CEREBRO-SPINAL MENINGITIS.

(*For complete paper see page 351*).

Dr. H. S. UPSON, of Cleveland, read a paper in which he considered the relation between these affections. Dr. Mills had first suggested the possibility of a connection between the two. His own case was briefly as follows: A woman, aged twenty-seven, had intense pain and tenderness in the extremities, together with stupor and slight opisthotonos. No electrical examination could be made, because of the extreme hyperæsthesia. She had had a multiple neuritis a year before, but recovered. The autopsy revealed congestion of the pia of the brain and cord, with marked serious effusion, and a microscopic examination of the ulnar nerve revealed interstitial inflammation there. In the opinion of the author, the nerve trunk inflammation was not parenchymatous, but rather of the membranes, and was analogous to the process in the brain and cord; the nerve fibres were involved secondarily. He had not looked for bacteria.

Dr. MILLS naturally felt interested in the case. He had had an autopsy in one of his own cases. Portions of nerves and sections of the brain and cord had been examined by Dr. Gray, of Washington, and this examination had proved conclusively the association of neuritis with the cerebro-spinal meningitis.

Dr. SPITZKA referred to the vacuoles in the author's sections, and said retarded lymph outflow might be important in causing the death of tissue and the formation of gas bubbles which these vacuoles must be considered to represent. He had noted also two bodies in the section larger than ordinary leucocytes, very delicately stained, which the author should have carefully delineated.

CASE OF ABSCESS OF THE BRAIN; OPERATION; DEATH ON THE NINTH DAY.

(*For complete paper see page 329.*)

Dr. C. K. MILLS, of Philadelphia, gave an abstract of a paper on this subject by Dr. J. T. ESKRIDGE, of Denver. The patient had had typhoid fever. Two months later there was purulent inflammation of the middle ear, and not long after symptoms of brain irritation followed, such as headache, delirium, and persecutory delusions, together with paralysis of the right hand and the right angle of the mouth. The skull was trephined over the face and hand centres, and a purulent inflammation was found under the dura. The wound was then dressed, and the patient died nine days later. A widespread suppurative meningitis was found at the autopsy. Dr. Mills thought the case of great practical value. He thought trephining should have been performed in two places—at the center, which had been properly localized, and also over the mastoid region, where the inflammatory process had originated.